

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NUMBER AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

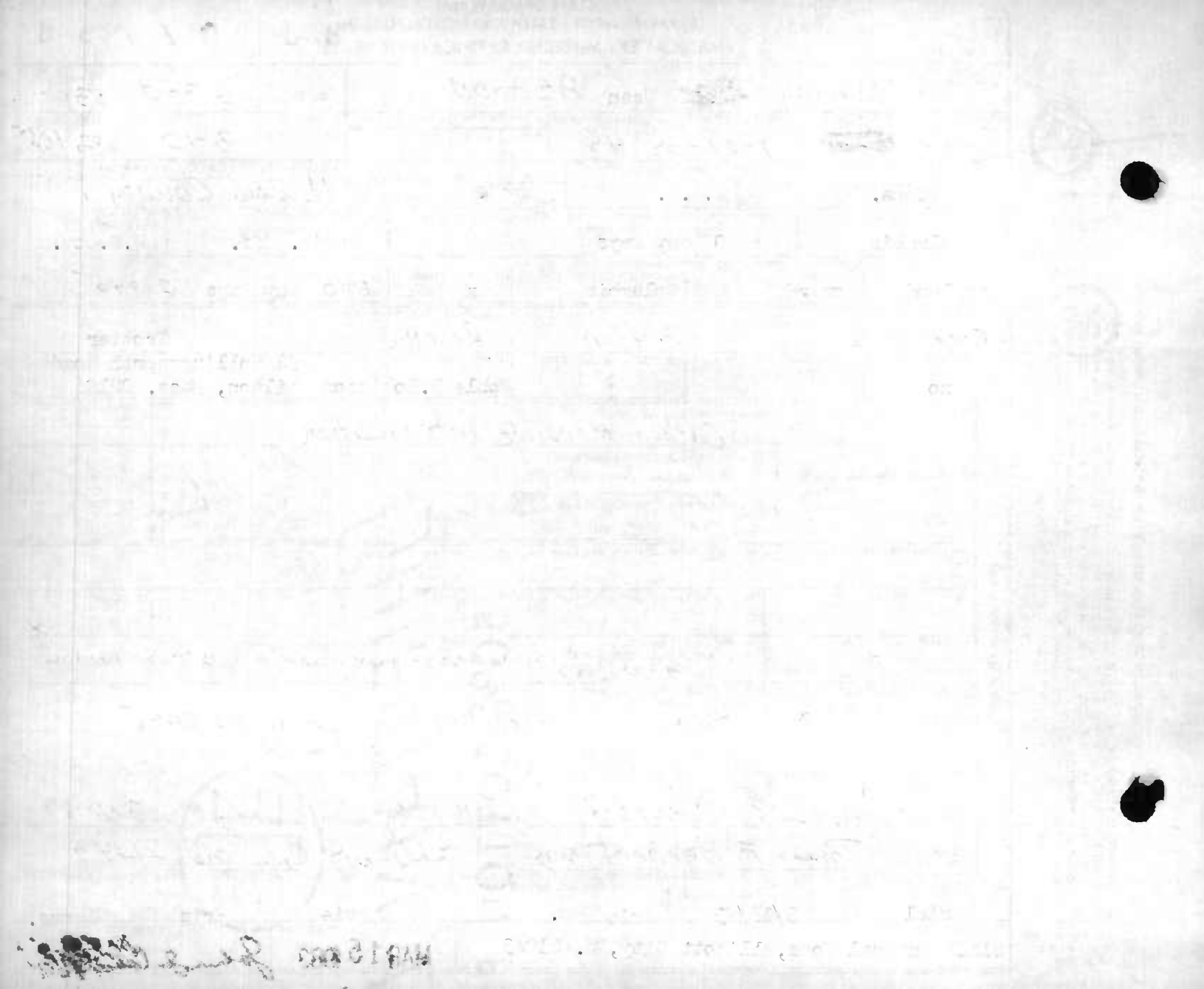
DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
Dorothy		Jean		BEASON		3-10 1983		M	
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Female	White	9-22-34		48 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Penna.		U.S.A.		MARRIED		NEVER MARRIED		Howard County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
Columbia		6860 Many Days		Admin. Off.		U.S. Gov.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Howard		Columbia		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6860 Many Days 21045	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Oscar		Beason		no		?		Noble R. Robinson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?			
PART I DEATH WAS CAUSED BY:						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
IMMEDIATE CAUSE (a) Carbon monoxide intoxication									
9520									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		Sat in auto in closed garage with motor running.					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>		AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		Home		6860 Many Days Columbia, Md 21045			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED					
Thomas F. Herbert		M.D. Deputy		3-10-83					
EXAMINER'S NAME		ADDRESS							
Thomas F. Herbert, M.D.		Ellicott City, Md 21043							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. REGISTRAR'S SIGNATURE	
Burial		3/16/83		Erie Cem.		Erie		Erie	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
SLACK Funeral Home, Ellicott City, Md. 21043		MAR 15 1983		James E. Carver					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 7 7 5 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joseph C. Best Sr.</i>			2a DATE OF DEATH MONTH DAY YEAR <i>3 2 83</i>		2b. HOUR <i>7<sup>25</sup> PM</i>
3. SEX <i>Male</i>	4 RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11 20 20</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <i>Howard Co.</i> MD.		
10 CITY OR TOWN OF DEATH <i>Columbia</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County General</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Claims Inspector</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>MD. 21043</i>
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Howard</i>	13c. CITY OR TOWN <i>Ellicott City</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Albert W. Best, Sr.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary K. Kennis</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>215-16-0944</i>		17. INFORMANT ADDRESS <i>Mrs. Marguerite Best, Same as above</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive pleural effusion &amp; respiratory failure</i> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Metastatic Carcinoma of Pancreas</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/2</i> 19 <i>83</i> , to <i>3/2</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>3/2</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Brad Cooper</i>		DEGREE		22c. DATE SIGNED <i>3/2/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BRAD J COOPER, MD</i>		22e. ADDRESS <i>3459 St John's Lane, Ellicott City, Md. 21043</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>March 5, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park</i>	
23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>Elkridge Howard Co. Md.</i>					
24 FUNERAL DIRECTOR NAME <i>McCutty Funeral Home, 130 E. Font Ave. Balto. Md.</i>		25a. REC'D BY REGISTRAR <i>21230</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Lohr</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 0 7 7 6 10		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		20. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
GEORGE MONROE BOWERSOX				3 1 83		4 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		1 15 01		82 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Howard County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Harwood		6407 Loudon Avenue		Carpenter		---			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Howard		Harwood		6407 Loudon Avenue		21227	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Charles Bowersox		Elizabeth Shaffer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
NO		220-38-9654		Anna H. Bowersox		6407 Loudon Avenue		21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4920 IMMEDIATE CAUSE (a) Congestive heart Failure									
DUE TO, OR AS A CONSEQUENCE OF (b) Severe emphysema									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec. 12, 1983, to March 1, 1983, that (I) (we) last saw the deceased alive on March 1, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
James E. Rowe M.D.		March 3, 83		Dr. James Rowe		413 Commonwealth Avenue			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		3/4/83		Meadowridge Mem. Pk.		Elkridge Howard Maryland			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hubbard Funeral Home, Inc.		4107 Wilkens Ave. 21229		MAR 4 1983		J. A. J. Connel			

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) T. J. Bowling			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 3 23 19 83			2b. HOUR M 2:26		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1925	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD 3 23 19 83	2d. HOUR M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard County, MD.			
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Howard	13c. CITY OR TOWN Glenwood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2509 Hobbs Rd. 21738		
14. FATHER'S NAME FIRST MIDDLE LAST John Bowling				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Irene Bowling - Glenwood, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dennis F. Smyth, M.D.			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 3-23-83		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-26-83		23c. NAME OF CEMETERY OR CREMATORY Crottan Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Manassasville Howard Md.		
24. FUNERAL DIRECTOR Harry W. Haight, Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR MAR 28 1983		25b. REGISTRAR'S SIGNATURE Dennis F. Smyth		

10110

MASTERSHIP TEST  
JANUARY 1950  
JANUARY 1950

10110





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbonpapers and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		RUTH E. BURNS		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8307762		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUTH E. BURNS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3-9-83</b>		2b. HOUR <b>5:15 AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-26-13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LORIAN NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>ELLCOTT CITY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>4200 HERMITAGE DRIVE 21043</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM DeVoe</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA BELLE SWOPE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>191-03-1107</b>		17. INFORMANT <b>GEORGANN KUBIAK</b>		ADDRESS <b>SAME AS # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b> <b>4049</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MOS</b> <b>YRS</b> <b>YRS.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CONGESTIVE HEART FAILURE; DIABETES MELLITUS</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>1977</u> , 19____, to <u>3.9.83</u> , 19____, that (we) lost saw the deceased alive on <u>3.9.83</u> , 19____, and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If I feel I did not see the body after death, I so state.)									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T.A. DADISMAN</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3.9.83</b>	
22d. ADDRESS <b>5999 HARRIS FAN RD COLUMBIA MD 21044</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/12/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CIRCLE HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PUNXSUTAWNEY PENNSYLVANIA</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>LEON M. &amp; RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS RD., COLUMBIA, MD. 21045</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1. FOR STATE REGISTRAR RONALD LEYMOYNE CASE CERTIFICATE OF DEATH											
REG. NO. 83 07763											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RONALD L. CASE					2a. DATE OF DEATH MONTH DAY YEAR 3 28 83					2b. HOUR 7:15 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 16, 1937		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.					
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COMPUTER ENG.		12b. KIND OF BUSINESS OR INDUSTRY BENDIX CORP.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST PAUL FRANCIS CASE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET ETHEL CRISWELL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) KOREAN		17. INFORMANT MRS. ANGIE CASE			ADDRESS SAME AS # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5860 CARDIAC ARREST DUE TO VENTRICULAR DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE 2° POLYCYSTIC DUE TO, OR AS A CONSEQUENCE OF (c) URETERIA & HYPERKALEMIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from on 3/28/83, 19 83, to 3/28/83, 19 83, that (I) (we) last saw the deceased alive on 3/28/83, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE RUFACEL					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/28/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUFACEL					22e. ADDRESS 10840 LITTLE PATUXENT PKY, COV, MD 21044						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/31/83		23c. NAME OF CEMETERY OR CREMATORY MD. VETERANS CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE A.A. MD.			
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045					25. DATE REC'D. BY REGISTRAR APR 4 1983						
REGISTRAR'S SIGNATURE John J. Connel											

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

HOUSE OF REPRESENTATIVES

COMMITTEE ON SELECT COMMITTEES  
SUBCOMMITTEE ON INVESTIGATIONS

NEW YORK, NEW YORK  
JUNE 1, 1963

MEMORANDUM FOR THE CHAIRMAN

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

APR 1 1963  
J. Edgar Hoover

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16.50M/7/77  
(VR A 15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 0 7 7 6 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herman Joseph Feaga				2a. DATE OF DEATH MONTH DAY YEAR March 18, 1983			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb 5, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3600 CENTENNIAL LANE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMING		12b. KIND OF BUSINESS OR INDUSTRY FARM	
13a. STATE Maryland				13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Feaga				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Kienne			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-07-9191		17. INFORMANT GRETCHEN FEAGA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma, @lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cancer cachexia</u>							
19a. DATE OF OPERATION 11/10/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (L) Parasternal Exploration		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 3, 1982</u> to <u>Jan 25, 1983</u> , that (I) (we) last saw the deceased alive on <u>Jan 25, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph J. Romolo MD (for R. Currie MD)				22c. DATE SIGNED 3/18/83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. L. Romolo MD	
22e. ADDRESS Columbia Med. Plaw, Columbia, Md.				22f. DATE REC'D. BY REGISTRAR MAR 23 1983			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-21-83		23c. NAME OF CEMETERY OR CREMATORY ST Louis CEM		23d. LOCATION CITY OR TOWN COUNTY STATE Blacksville Howard, MD.	
24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Md. 21043				25. REGISTRAR'S SIGNATURE R. Currie			



DATE: 10/1/80 BY: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

0 7 7 6 5

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MILDRED FERNANDEZ		2a. DATE OF DEATH MONTH DAY YEAR 3 2 83	
3. SEX Female		4. RACE Black	
5. DATE OF BIRTH MONTH DAY YEAR May 28 1933		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Howard Co., Md.		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co. MD.	
10. CITY OR TOWN OF DEATH Columbia, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9404 Wandering Way	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Sec.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY How.	
13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 9404 Wandering Way 21045			
14. FATHER'S NAME FIRST MIDDLE LAST Clifton T Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Evans	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 215-28-2324	
17. INFORMANT ADDRESS Manuel Fernandez 9404 Wandering Way 21045			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2.5 years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Feb 19 83, and that if (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE MARVIN J. FELDMAN MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 3-3-83		22d. ADDRESS 302 Green Spring Station Cutherville MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 3/5/83	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HGTS. AVE.		25. DATE REC'D. BY REGISTRAR MAR 4 1983	
25b. REGISTRAR'S SIGNATURE John J. Carver			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2015-2016  
[Faint header text and a large handwritten '3' in the top right corner]

[Faint, mostly illegible text in the middle section of the page, possibly containing a list or table]

[Faint, mostly illegible text in the lower middle section of the page]

[Faint, mostly illegible text at the bottom of the page, including what appears to be a signature and a date]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 7 7 6 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALMA M. FERGUSON			2a. DATE OF DEATH MONTH DAY YEAR MAR 10 83			2b. HOUR 5 <sup>10</sup> P M	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 10 15		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Trent		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETTIE R. THURMAN		13e. STREET ADDRESS 2525 ARTHUR AVE 21784			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-34-8684		17. INFORMANT Robert Ferguson Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Breast Cancer, metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Adult onset Diabetes mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-13</u> , 19 <u>83</u> , to <u>3-10</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>3-10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Long S. Hsu</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-10-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Long S. Hsu, M.D.		22e. ADDRESS 4922 Ten Mills Rd, Columbia, Md 21044					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-14-83		23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery		23d. LOCATION (CITY OR TOWN) COUNTY STATE Sykesville Carroll Md.	
24. FUNERAL DIRECTOR NAME Harry W. Haight		ADDRESS Sykesville, Md.		25. DATE REC'D. BY REGISTRAR MAR 14 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

MEDICAL CERTIFICATION

THE UNIVERSITY OF CHICAGO

1912

Received of the Treasurer of the University of Chicago  
the sum of \$100.00 for the year 1912

Yours very truly

1912

W. B. E. [Signature]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 7 7 6 7

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lillie M. Flowers</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 / 22 / 83</i>		2b. HOUR <i>11:14 A</i>		
3. SEX <i>F</i>		4. RACE <i>C</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 - 25 - 92</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard</i> MD.	
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County General</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>HOWARD</i>		13c. STREET ADDRESS <i>PHILA. AVE &amp; 20th St.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>FRANK AARON</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>IDA SIMMONS</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO.	
17. INFORMANT (daughter) <i>Mrs. Shirley Phillips, same as 13e</i>		18. ADDRESS <i>Ocean City, Md.</i>		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>4379 IMMEDIATE CAUSE (a) Cardiorespiratory arrest.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiovascular disease</i>			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/22/83</i> , 19 <i>83</i> , to _____, 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Levan Kulk</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>3/22/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LEVAN KULK</i>		22e. ADDRESS <i>HOWARD CO. GEN. HOSP COLUMBIA MD.</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>25 MAR. 25, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>DORCHESTER MEM. PK.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>ALREY, CAMBRIDGE, DORCHESTER, MD.</i>	
24. FUNERAL DIRECTOR NAME <i>CURRAN FUNERAL HOME, 308 High St., Cambridge, Md. 21613</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 29 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

TO HOSPITAL-OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified of case.



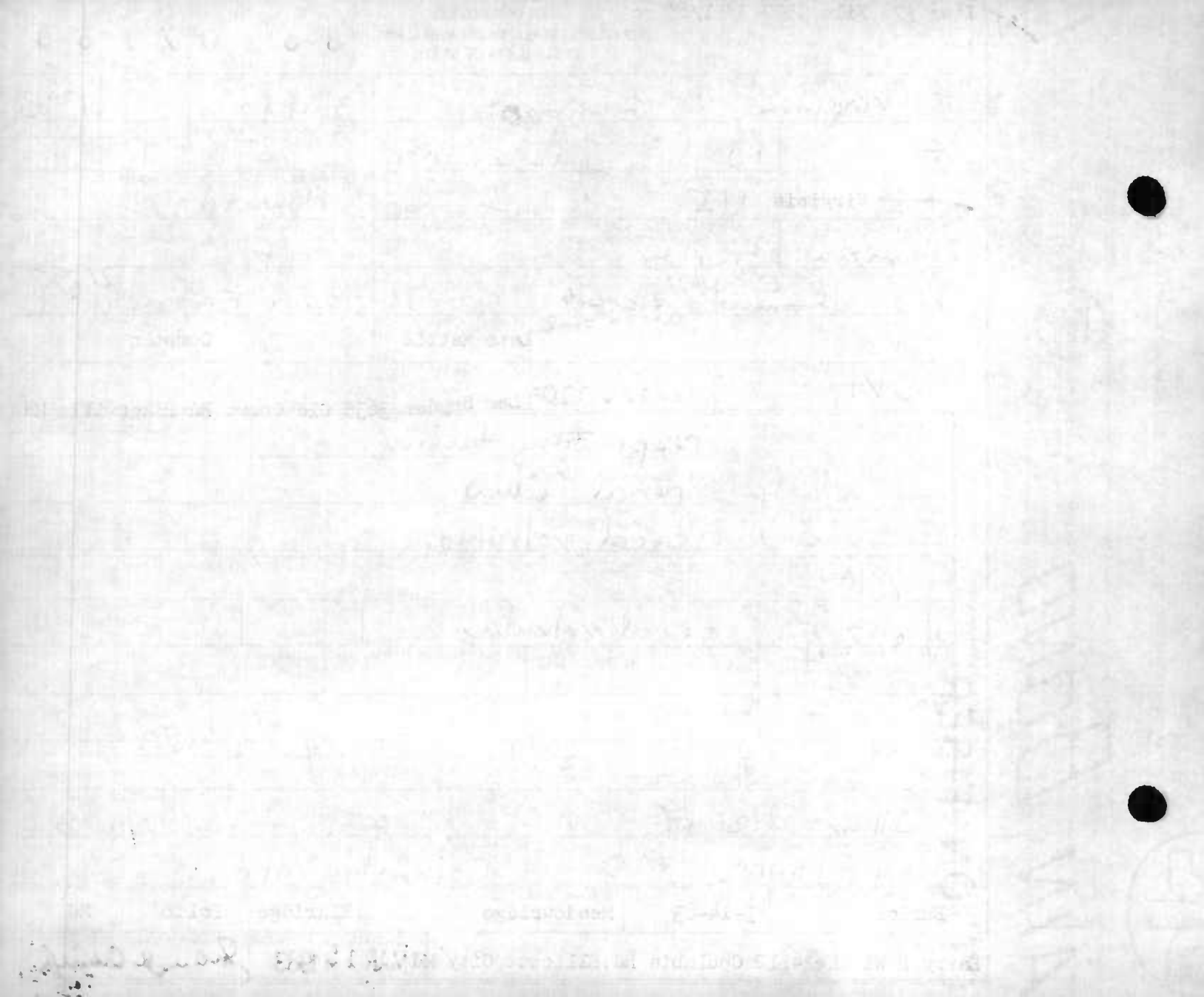
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, this certificate should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item #7a Film G577 3/31/83 rc		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 3 0 7 7 6 8	
1- FOR STATE REGISTRAR		REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Virginia Giampoli</i>			2a DATE OF DEATH MONTH DAY YEAR <i>3/11/83</i>		2b HOUR <i>1:30 p.m.</i>
3 SEX <i>F</i>	4 RACE <i>W</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>12 24 07</i>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <i>75</i> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Howard</i> MD	
10 CITY OR TOWN OF DEATH <i>Columbia</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HCG H</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>ret.</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) STATE <i>MD Howard</i>		13b. CITY OR TOWN <i>Ellicott City</i>		13c. STREET ADDRESS <i>15501 Frederick Rd</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>W R Woodbine</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Late Mattie Compton</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>N/A</i>		16b SOCIAL SECURITY NO. <i>22036 7708</i>		17 INFORMANT ADDRESS <i>Lee Snyder 3635 Old Court Rd Pikesville Md</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure.</i> 5602 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>renal failure</i> (c) <i>cecal volvulus.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>N/A</i>					
19a DATE OF OPERATION <i>3/6/83</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>cecal volvulus.</i>		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>N/A</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/4</i> 19 <i>83</i> to <i>3/11</i> 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>3/11</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>William H. Hunt</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>3/11/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm Flowers</i>		22e. ADDRESS <i>Columbia Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-14-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge</i>	
23d. LOCATION (SPECIFY) <i>Elkridge</i>		COUNTY <i>Balto</i>		STATE <i>Md</i>	
24 FUNERAL DIRECTOR NAME <i>Harry H Witzke</i>			25a. DATE REC'D. BY REGISTRAR <i>MAR 15 1983</i>		
ADDRESS <i>4112 Coulmbia Rd, Ellicott City Md</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>		

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

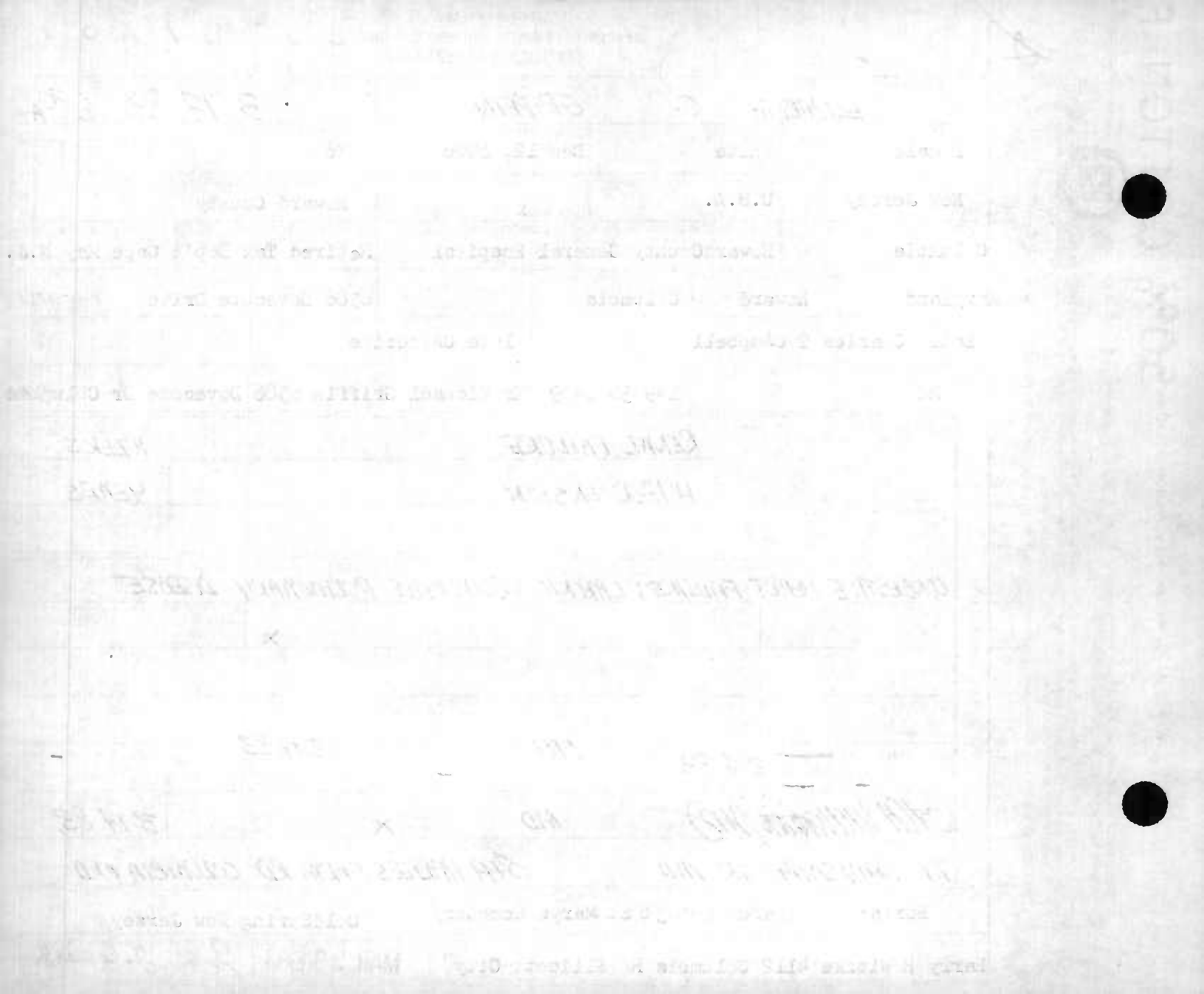
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 3 0 7 7 6 9
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH C. GRIFFIN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3 17 83</b>			2b. HOUR <b>6:30 AM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 12, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Tax Dept</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cape May N.J.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST LAST <b>late Charles T Campbell</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Catherine</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>149 30 6499</b>		17. INFORMANT ADDRESS <b>Mr Michael Griffin 6586 Dovecote Dr Columbia</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b> <b>4039</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>WEEKS</b> <b>YEARS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>CONGESTIVE HEART FAILURE; CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>1981</b> , 19____, to <b>3.17.83</b> , 19____, that (I) <del>(we)</del> last saw the deceased alive on <b>3.16.83</b> , 19____, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(do)</del> view the body after death.										
22b. SIGNATURE OF PHYSICIAN <b>T.A. DADISMAN JR MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>3.17.83</b>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T.A. DADISMAN JR MD</b>				22e. ADDRESS <b>5999 HARRIS FARM RD COLUMBIA MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>March 21, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Marys Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cold Spring New Jersey</b>				
24. FUNERAL DIRECTOR NAME <b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 23 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>				

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 7 7 7 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Richard Baker Groves			2a. DATE OF DEATH MONTH DAY YEAR 3 / 31/ 83			2b. HOUR 6:06 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11/ 2/1895		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Business		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21620 Colonial Manor Apts Apt. 6-D	
14. FATHER'S NAME FIRST MIDDLE LAST James Henry Groves			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA Baker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. 2021 RELEASE UNDER E.O. 14176 222-12-2966			17. INFORMANT ADDRESS Hospital Records-Chestertown, Maryland 21620				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident, Rt. Hemisphere 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cerebrovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from March 25, 1983, to March 31, 1983, that (1) (we) last saw the deceased alive on March 30, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Charles P. Adams MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED April 1, 1983				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles P. Adams M.D.						22e. ADDRESS Chestertown, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/2/83		23c. NAME OF CEMETERY OR CREMATORY CHURCH HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CHURCH HILL DA. MD.			
24. FUNERAL DIRECTOR Mawm V. Williams Jr. CHESTERTOWN MD						25a. DATE REC'D. BY REGISTRAR APR 7 1983		25b. REGISTRAR'S SIGNATURE John J. Coburn		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 constitute the permit within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



13011-101101-802

WOOD WARE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the deceased, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 7 7 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Grace E. Hall</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>March 24, 1983</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 29, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.	
10. CITY OR TOWN OF DEATH <b>Jessup</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7961 Old Jessup Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Jessup</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Oliver Merson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO <b>220-34-6942</b>	
17. INFORMANT ADDRESS <b>Richard A. Hall, Jr same as above</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, CHF, Ventricular Arrhythmia</b>						Years <b>2500</b>	
(c) <b>Diabetes mellitus</b>						Years <b>2500</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Peripheral Vascular Disease, Tachycardia, Ischemia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>August 1980</b> to <b>March 24 1983</b> , that (I) (we) lost the deceased alive on <b>March 22 1983</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John I. Levine</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/24/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John I. Levine, MD</b>				22e. ADDRESS <b>10802 Hickory Ridge Rd, Columbia, MD 21044</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>March 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Donaldson Funeral Home, Laurel, Md</b>				25a. DATE REC'D BY REGISTRAR <b>MAR 31 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John I. Levine</b>	

BP

1164

9. 10. 11.

1061

MAR 31 1989



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST WILLIAM			MIDDLE ERVIN			LAST HARRIMAN			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 3 14 1983			2b. HOUR M 2:45		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1908		6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 14 1983			2d. HOUR P M 2:45		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Howard County, MD.					
10. CITY OR TOWN OF DEATH Dorsey				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1-95 1 mi. so. of Rt. 100				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rigger Boss U.S. Coast Guard				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 800 Seaward Road 21204									
14. FATHER'S NAME FIRST MIDDLE LAST Hugh Harriman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Kramp													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1932-1934		16c. CITY OR TOWN 219-03-6441		17. INFORMANT Mrs. Kathryn Ann Harriman						ADDRESS Same as #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 1:55 P.M. 3-14- 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/truck collision.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1-95 1 mi. so. of Rt. 100, Dorsey, Howard, Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Ann M. Dixon, M.D.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 3-15-83									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St., Balto., Md. 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-18-1983				23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore, Md.					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS 1050 York Road Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR MAR 17 1983				25b. REGISTRAR'S SIGNATURE John J. Casper					



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U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

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U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

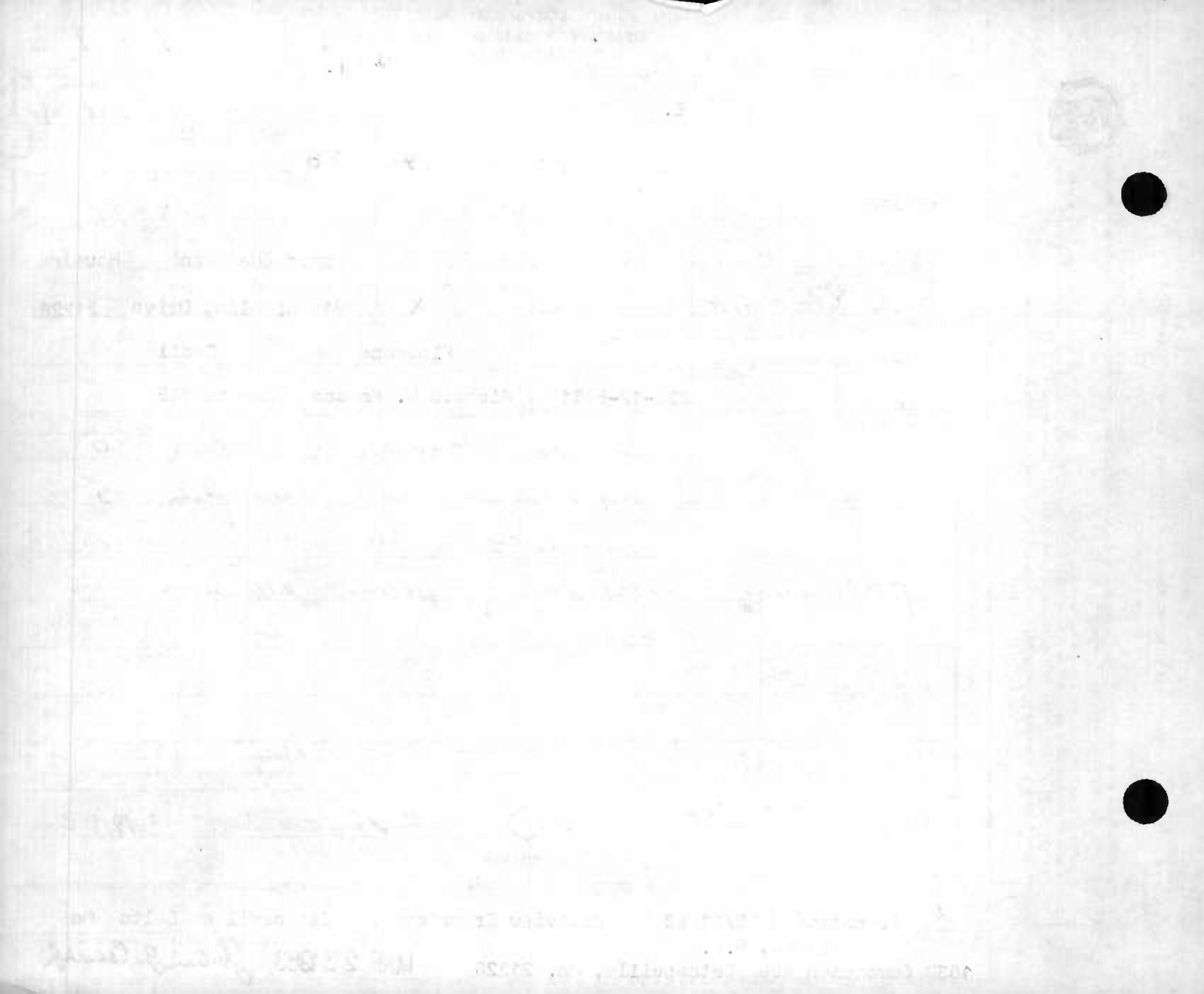
DHMH-16 50M 1/81  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

0 7 7 7 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT E. KANODE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 18 83</b>			2b. HOUR <b>6:15 PM</b>			
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 10 4 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD COUNTY GEN. HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Board Chairman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housing</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md</b> 13a. COUNTY <b>Baltimore</b>					13b. CITY OR TOWN <b>Catonsville</b>		13c. STREET ADDRESS <b>916 Rambling Drive 21228</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert E. Lee Kanode</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Cecil</b>			17. INFORMANT ADDRESS <b>Richard W. Kanode Same as #13</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-12-8981</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Cardiac Standstill with apnea</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>thromboembolism with renal failure 5 yr</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Disease 10 yr</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>pulmonary congestion; pleural effusion</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (this hospital) attended the deceased from <b>June 19 82</b> to <b>3/18 83</b> , that (i) (we) lost saw the deceased alive on <b>3/18/83</b> 19 <b>83</b> , and that (ii) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James J. Carey MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/19/83</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James J. Carey</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3/21/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto Md</b>			
24. FUNERAL DIRECTOR NAME <b>Witzke, P.A.</b>				ADDRESS <b>1630 Edmondson Ave Catonsville, Md. 21228</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 23 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 07774			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>ONA KARALIUS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 5 83</b>		2b. HOUR <b>M</b>	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 26 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LITHUANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD</b> MD			
10. CITY OR TOWN OF DEATH <b>ELLCOTT CITY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10130 GREEN CLOVER DR.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SEAMSTRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING MAN</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>HOWARD</b>	13c. CITY OR TOWN <b>ELLCOTT</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>21043 10130 GREEN CLOVER DR.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ADOMAS TARASEVICIUS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BLASKIEVICIUS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>313-30-5371</b>		17. INFORMANT ADDRESS <b>VINCAS KARALIUS 914 MASEFIELD RD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC BREAST CA.</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) this hospital attended the deceased from <b>MARCH 3 1983</b> to <b>MARCH 5 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22a. SIGNATURE <b>DR. DIANA H. GRIFFITHS</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/8/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DIANA H. GRIFFITHS</b>		22e. ADDRESS <b>900 CATON AVE. BALT. MD 21209</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/9/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		23d. LOCATION <b>BALTO</b> COUNTY <b>MD</b> STATE	
24. FUNERAL DIRECTOR <b>WEBER FUNERAL HOME</b>		NAME <b>EDMONDSON</b> ADDRESS <b>5311</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 9 1983</b> REGISTRAR'S SIGNATURE <b>John J. Canine</b>			



20% COTTON LITER

CHARTER

March 2, 1951

July 11, 1951

TO THE BOARD OF DIRECTORS  
OF THE  
ATLANTA-CLARK COUNTY  
AIRPORT AUTHORITY  
FROM  
THE  
ATLANTA-CLARK COUNTY  
AIRPORT AUTHORITY

RECEIVED BY THE BOARD OF DIRECTORS  
MAY 8 1951  
ATLANTA-CLARK COUNTY  
AIRPORT AUTHORITY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07775

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 3-16-83 19										2b. HOUR M 00	
1. DECEASED NAME (TYPE OR PRINT) ROBERT D. ONALD KARWOSKI										2c. DATE PRONOUNCED DEATH 3-16-83 19										2d. HOUR M 7:50A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 23, 1956		6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.									
10. CITY OR TOWN OF DEATH Ellicott City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 9120 Frederick Road								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) food handler				12b. KIND OF BUSINESS OR INDUSTRY restaurant					
13a. STATE Maryland				13b. COUNTY Prince Georges				13c. CITY OR TOWN Laurel				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				13e. STREET ADDRESS 15407 Laurelton Drive 20707					
14. FATHER'S NAME FIRST JOHN H. MIDDLE KARWOSKI LAST 20707										15. MOTHER'S MAIDEN NAME FIRST THERESA A. MIDDLE CHRZAN LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				(IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 219 68 2876				17. INFORMANT ADDRESS John H. Karwoski same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9350 IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 3-16-83 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged self													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) churchyard 60'				21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) Johns E. of Educational Bldg. Howard Co., Md.													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>Maigite McNeill</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 3-17-83									
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D.				ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE March 19, 1983				23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem				23d. LOCATION (CITY OR TOWN COUNTY STATE) Wheaton, Maryland									
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md										25a. DATE REC'D. BY REGISTRAR MAR 24 1983						25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the funeral home after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
FOR 1. STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET Coyle King</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MAR. 28, 1983</b>			2b. HOUR <b>3:5 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 4 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Columbia Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5775 Sweetwind Pl 21045</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Admin. ass.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Administration</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE <b>Md</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13e. STREET ADDRESS <b>5775 Sweetwind Pl 21045</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William F. Coyle</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bridget Murphy</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>—</b>					16b. SOCIAL SECURITY NO. <b>219-30-5703</b>		17. INFORMANT ADDRESS <b>Stephanie M. King 5775 Sweetwind Pl. Columbia Md 21045</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lung Metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lung Cancer</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>3 mo</b> <b>7 mo.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>10/13</b> , 19 <b>82</b> , to <b>3/28</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>3/17</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>William C Waterfield</b> M.D.					DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>3/29/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William C Waterfield</b>					22e. ADDRESS <b>St Agnes Hospital 900 Caton Ave Balt Md 21229</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/30/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Ho. Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>SLACK Funeral Home 3871 Columbia Rd 21043</b>					25a. DATE REC'D. BY REGISTRAR <b>APR 5 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lannan</b>		

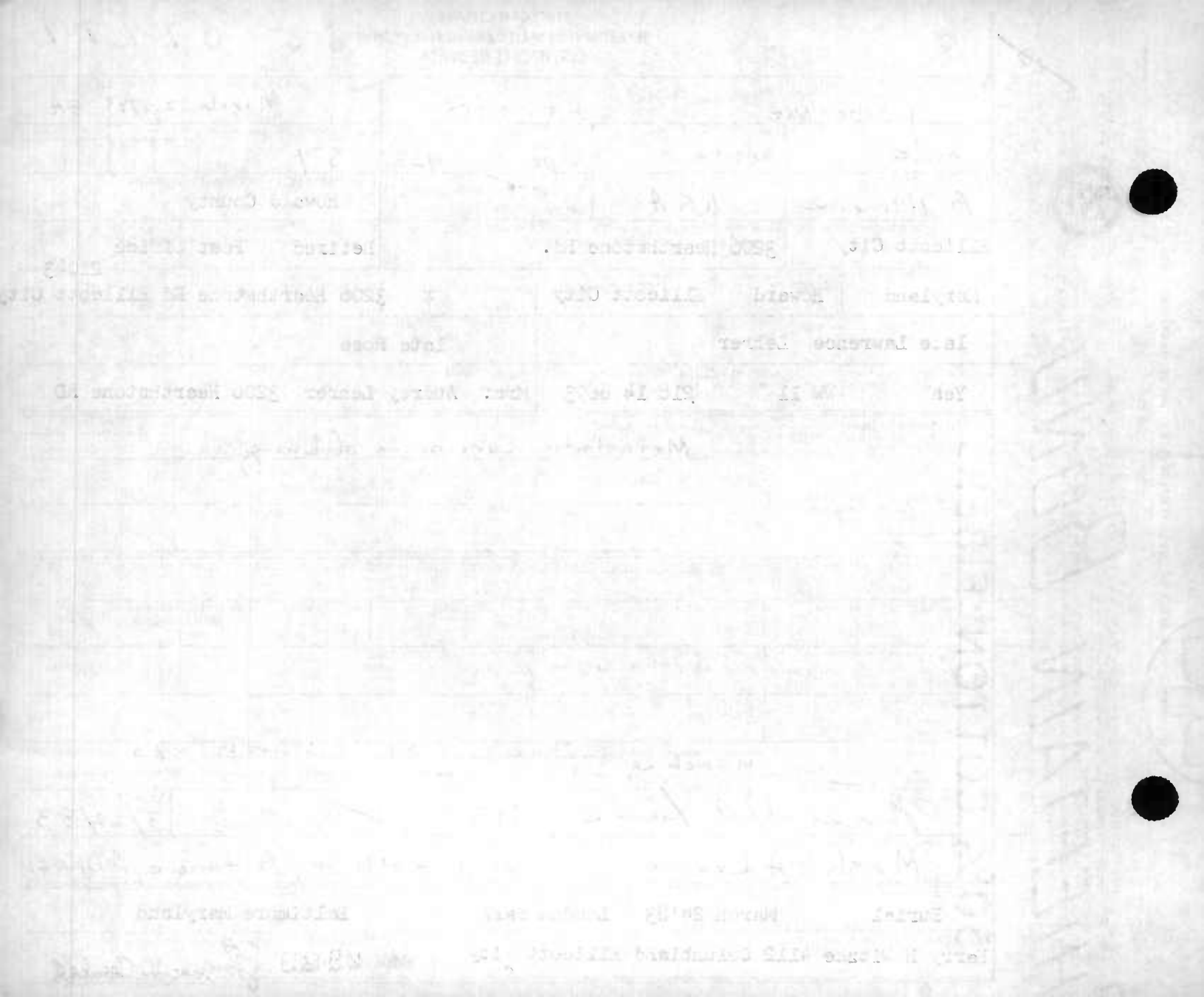


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 83 07777									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lawrence Lehrer					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR March 22, 1983 8A M				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept 25 1923		6. AGE (IN YEARS LAST BIRTHDAY) YRS 59		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howa d County MD.			
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 3206 HEARTHSTONE RD.				12a. USUAL OCCUPATION Retired		12b. KIND OF BUSINESS OR TYPE OF WORK FOR MOST OF WORKING LIFE Post Office 21043	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Howard				
13c. CITY OR TOWN Ellicott City					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST late Lawrence Lehrer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Rose				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN Yes		16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT Mrs. Audrey Lehrer		ADDRESS 3206 HEARTHSTONE RD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Metastatic Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 19 83, to March 19 83, that (I) (we) lost saw the deceased alive on March 22, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marshall A. Levine					DEGREE MD			22c. DATE SIGNED 3/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marshall A. Levine					22e. ADDRESS 711 W. 4th St, Baltimore, MD, 21211				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 24 '83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR Harry H Witzke					25a. DATE REC'D. BY REGISTRAR MAR 23 1983		25b. REGISTRAR'S SIGNATURE John J. Canine		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				83 07778	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY I. MANNING</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3-10-83</b>	
3. SEX <b>F</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 17 02</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASS.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>80</b>	
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LORIED NURSING HOME</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Bank Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>late James H Douglas</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Sarah J Douglas</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>023-30-9339</b>		17. INFORMANT ADDRESS <b>Donald Manning 4710 Parkvale Rd 21043</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b> <b>4049</b> DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF, (c) <b>Hypertensive A.S.C.V.D.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>10 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>4-25</b> , 19 <b>72</b> , to <b>3-10</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>3-10</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Thomas F. Herbert, MD</b>				22c. DATE SIGNED <b>3-10-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas F. Herbert, MD</b>				22e. ADDRESS <b>3779 Church Rd. Ellicott City, MD 21043</b>	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>March 15, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Winthrop Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Winthrop, Mass.</b>		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1983</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NEIL J MARSH			2a. DATE OF DEATH MONTH DAY YEAR 3 22 83			2b. HOUR 1:20 PM			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 16 31		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY, MD.			
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY U.S. Customs	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md.			13b. CITY OR TOWN P.G.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 15808 KERR Rd. 20707		
14. FATHER'S NAME FIRST MIDDLE LAST Neil Marsh			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Vail						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. IF YES, GIVE WA OR DATES 1950-1954		17. INFORMANT ADDRESS Betty Ann Marsh Same as #13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure (c) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 hours Weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cerebrovascular Accident									
19a. DATE OF OPERATION 12/8/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary artery disease			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED: WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/8 1983 to 3/22 1983, that (I) (we) lost saw the deceased alive on 3/22 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.									
22b. SIGNATURE Jerome H. ... MD						DEGREE		22c. DATE SIGNED 3/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 25 Mar 83		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.		
24. FUNERAL DIRECTOR NAME 7601 Sandy Spring Rd. Laurel Md						25a. DATE REC'D. BY REGISTRAR MAR 28 1983		25b. REGISTRAR'S SIGNATURE Joan J. ...	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07780

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR										2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2c. DATE ESTIMATED <input type="checkbox"/> MONTH DAY YEAR		2d. HOUR			
MARIAN		W.		McCENEY				3-25-83		M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 YRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR			
FEMALE	WHITE	OCT 6, 1910		72 YRS.				3-25-83		8:06			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		U.S.A.				Howard County				MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
COLUMBIA		Howard Co. General Hospital		REGISTER NURSE									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		HOWARD		COLUMBIA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9629 WHITE ACRE ROAD		21045			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NEWTON		MAMIE		NO		578-36-0007		BENJAMIN B. McCENEY, SR.		SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) 9110		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
				(b)		DUE TO, OR AS A CONSEQUENCE OF							
				(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. (BODY ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION									
WHITE <input type="checkbox"/> NOT WHITE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>		home		9629 White Acre Rd. Columbia, Maryland									
22a. I certify that I took charge of the remains of the deceased (BODY ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE SIGNED							
ACTUAL SIGNATURE		Thomas D. Smith, M.D.		Deputy Chief		MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.		ADDRESS		111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
BURIAL		3/30/83		ST. BARNABAS EPISCOPAL		UPPER MARLBORO							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
FRANCIS J. COLLINS		APR 4 1983		John J. Connelley									
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901													

THE UNIVERSITY OF CHICAGO  
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500 EAST 57TH STREET, CHICAGO, ILL. 60637

2

LIBRARY  
UNIVERSITY OF CHICAGO



2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR <b>ELMA PEARL MEYER</b>		REG. NO. <b>8 3 0 7 7 8 1</b>							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELMA Pearl Meyer</b>					2a DATE OF DEATH MONTH DAY YEAR <b>3-28-83</b>			2b HOUR <b>9:30 PM</b>	
3 SEX <b>Female</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3 3 28</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEBRASKA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY MD.</b>			
10 CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD COUNTY GENERAL HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <b>MD.</b>		13b COUNTY <b>Howard</b>		13c CITY OR TOWN <b>COLUMBIA</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>5263 BROOK WAY 21044</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EARL BOESL</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADA VAUGHN</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>491243487</b>		17 INFORMANT ADDRESS <b>W. EDGAR MEYER SAME AS # 13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ANNEURISM</b> <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>OVARIAN CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. S. SONS</b>				22e. ADDRESS <b>Columbia HG 64</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>3/30/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DORSEY A.A. MD.</b>			
24 FUNERAL DIRECTOR <b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES P.A.</b> 5555 TWIN KNOLLS ROAD, COLUMBIA, MARYLAND 21045						25a DATE REC'D. BY REGISTRAR <b>APR 4 1983</b>			
25b REGISTRAR'S SIGNATURE <b>[Signature]</b>									

MEDICAL CERTIFICATION

(M)

APR 4 1983  
J. J. J. J. J.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07782

1- STATE REGISTRAR		FOR	
1 DECEASED NAME (TYPE OR PRINT)		2a DATE KNOWN OF DEATH	
FIRST MIDDLE LAST Roger Wayne Robey		ESTIMATED MONTH DAY YEAR 3 7 1983	
3 SEX	4 RACE	5 DATE OF BIRTH (MONTH DAY YEAR)	6 AGE (IN YEARS LAST BIRTHDAY)
Male	White	Dec. 19, 1956	26 YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Maryland		U.S.A.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Elkridge		U.S. Rt. 1 north of Rt. 100	Laborer
13a STATE		13b COUNTY	13c CITY OR TOWN
Maryland		Howard	Elkridge
14 FATHER'S NAME (FIRST MIDDLE LAST)		15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	
Harry Spencer Robey Jr.		Martha Reeley	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
Yes		213-68-5523	Martha G. Athey same as #13
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> 8136 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY?			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		6:25 PM 3 7 1983	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
Bicyclist struck by tractor-trailer			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		street	
21f LOCATION STREET CITY OR TOWN COUNTY STATE			
Rt. 1 north of Rt. 100, Savage, Howard, Md			
22a I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
<i>Thomas D. Smith</i>		Deputy Chief	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS	
Thomas D. Smith, M.D.		111 Penn St. Balto., MD.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
Burial	3/10/83	Meadowridge Mem. Park	Baltimore, Howard, Maryland
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR	
FLECK FUNERAL HOME, INC.		MAR 9 1983	
7601 Sandy Spring Rd. Laurel, Md. 20707		REGISTRAR'S SIGNATURE	
		<i>John J. Connelley</i>	

RECEIVED  
MAR 9 1933



MAR 9 1933  
J. B. G. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 7 7 8 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) First MIDDLE LAST <u>Lula Mae Roberts</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>3-9-83</u>			2b. HOUR <u>2:25 PM</u>	
3 SEX <u>Female</u>		4 RACE <u>Caucasian</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>3 25 16</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>66</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Howard</u> MD.	
10 CITY OR TOWN OF DEATH <u>Columbia</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Howard County General Hosp.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13a. STATE <u>Md</u>		13b. COUNTY <u>Jessup</u>		13c. CITY OR TOWN <u>Howard</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <u>Box 239 D</u>		13f. ZIP CODE <u>20794</u>		14 FATHER'S NAME FIRST MIDDLE LAST <u>George Harvey Vaughn</u>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Arrie Watts</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>2500</u>		17 INFORMANT <u>Charles Roberts</u>		ADDRESS <u>same as above</u>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto CVA</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dissecting aortic aneurysm</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1wk</u> <u>4rs</u> <u>7rs</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION <u>2/16/83</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Acute Cholecystitis - Lithotripsy</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 28</u> , 19 <u>83</u> , to <u>March 9</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>March 9</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>L. L. L...</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/9/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Larry T. L...</u>		22e. ADDRESS <u>10802 Hickory Ridge Rd, Cat. W 2204</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Mar 12, 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Dorsey Md</u>	
24. FUNERAL DIRECTOR NAME <u>Donaldson Funeral Home</u>		ADDRESS <u>Md</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 17 1983</u>		REGISTRAR'S SIGNATURE <u>John J. Canfield</u>	

MEDICAL CERTIFICATION

MAILED 1937

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 7 7 8 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>John Robinson Slack</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>3 30 83</u>		2b. HOUR <u>2:50A</u>
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>09 - 25 24</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>58</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Howard County</u> MD.	
10. CITY OR TOWN OF DEATH <u>Columbia</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Howard County General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Director</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Funeral</u>	
13a. STATE <u>MD</u>		13b. COUNTY <u>Howard</u>	13c. CITY OR TOWN <u>Ellicott City</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <u>3864 Columbia Rd.</u> <u>21043</u>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Samuel Dallas Slack</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ethel Lucilla Arrington</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>WW II</u>	17. INFORMANT ADDRESS <u>Doris Thompson Slack</u> <u>Same</u> <u>21043</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Months</u> <u>Years</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  
Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) this hospital attended the deceased from <u>3/3</u> 19 <u>82</u> , to <u>3/30</u> 19 <u>83</u> , that (ii) (we) lost saw the deceased alive on <u>3/30</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (How) (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Jerome Hantman, MD</u>		DEGREE <u>MD</u>	22c. DATE SIGNED <u>3/30/83</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jerome Hantman, M.D.</u>		22e. ADDRESS <u>11085 Little Patuxent Pkwy. Columbia, Md.</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>April 2, 1983</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Ellicott City, Howard Co., Md.</u>
24. FUNERAL DIRECTOR NAME ADDRESS <u>Slack Funeral Home Ellicott City, Maryland</u>		25. DATE REC'D. BY REGISTRAR <u>APR 5 1983</u>	26. REGISTRAR'S SIGNATURE <u>John J. Carver</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07785	
1. DECEASED NAME (TYPE OR PRINT) <b>John F. Stumpf</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3/24/83</b>		2b. HOUR <b>9:50</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03 11 58</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>25</b> YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b>			
10. CITY OR TOWN OF DEATH <b>Laurel</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>S. Side I-95 at Laurel</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lift Truck</b>		
13a. STATE <b>Delaware</b>			13b. COUNTY <b>New Castle</b>		13c. CITY OR TOWN <b>Newark</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2004 Chelmsford Circle, 19713</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Stumpf</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>196-50-9603</b>			17. INFORMANT <b>121 W. Park Place; Newark, Del.</b> <b>William J. Warwick Funeral Home 19711</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Acute carbon monoxide intoxication</b> <b>9520</b> IMMEDIATE CAUSE (a) <b>9520</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>9520</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>9520</b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 3/24/83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Subject inhaled exhaust fumes</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>auto</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>South side of I-95 at Laurel Laurel How. Co. Md.</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>H. Guard</b>				TITLE (SPECIFY) <b>M.D.</b>				MEDICAL EXAMINER		DATE SIGNED <b>3/24/83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn St., Balto, Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>03-26-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canale</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO. 83 07786									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAUL WALTON WEAVER						2a. DATE OF DEATH MONTH DAY YEAR MARCH 11, 1983		2b. HOUR 3:30 P.	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD			
10. CITY OR TOWN OF DEATH Woodbine		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3521 Hipsley Mill Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trainer		12b. KIND OF BUSINESS OR INDUSTRY Horse Breeding	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md. 21734		13b. COUNTY Howard		13c. CITY OR TOWN Woodbine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3521 Hipsley Mill Rd. 21734	
14. FATHER'S NAME FIRST MIDDLE LAST John Walton Weaver				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary (Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 213-05-4265		17. INFORMANT ADDRESS Judy W. Tolson Wheaton, Md. 20902			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Carpal Tunnel Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks 2 wks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION 1981-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carpal Tunnel				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 65 3/11 83					
22a. I certify that (I) (this hospital) attended the deceased from 3/9/83 to 3/11/83, that (I) (we) last saw the deceased alive on 3/9/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we could not find the body after death, so state.)									
22b. SIGNATURE Dr. Charles Ligon				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED 3/11/83	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Charles Ligon				22f. ADDRESS Olney, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MARCH 15, 1983		23c. NAME OF CEMETERY OR CREMATORY MEADE MEMORIAL		23d. LOCATION WHITE POST, CLARKE COUNTY, VIRGINIA			
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE MD. 20879						25. DATE REC'D. BY REGISTRAR MAR 15 1983 REGISTRAR'S SIGNATURE John J. Carver			

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1983 MAR 15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 07787			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)			
FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR			
CHRISTOPHER M. WHITTAKER, JR.				03 25 83			
3. SEX				4. RACE			
MALE				WHITE			
5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS (LAST BIRTHDAY))			
08 14 21				61 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
MARYLAND				U.S.A.			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
ELKRIDGE				OFFICER			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12b. KIND OF BUSINESS OR INDUSTRY			
5718 LEAF LANE, 21227				CHESSIE CORP.			
13a. STATE				13b. COUNTY			
MARYLAND				HOWARD			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
ELKRIDGE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
CHRISTOPHER M. WHITTAKER, SR.				FRANCES BARKLAGE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
YES				WW II 214-14-1837			
17. INFORMANT ADDRESS				17. INFORMANT ADDRESS			
PAMELA GORDON 4026 MacALPINE ROAD				ELLICOTT CITY, MD. 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) acute coronary insufficiency							
DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic heart disease							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
N/A							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
N/A				N/A			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 19 75 to 3-24 19 83, that (1) (we) lost saw the deceased alive on 3-24 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
ROGER L. GORDON				326-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
ROGER L. GORDON, M.D.				5411 OLD FREDERICK RD, CATONSVILLE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
BURIAL				03-28-83			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
ST. AUGUSTINE CH. CEM.				ELKRIDGE HOWARD MARYLAND			
24. FUNERAL DIRECTOR NAME				24. FUNERAL DIRECTOR ADDRESS			
HUBBARD FUNERAL HOME, INC.				4107 WILKENS AVE. 21229			

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CHILD

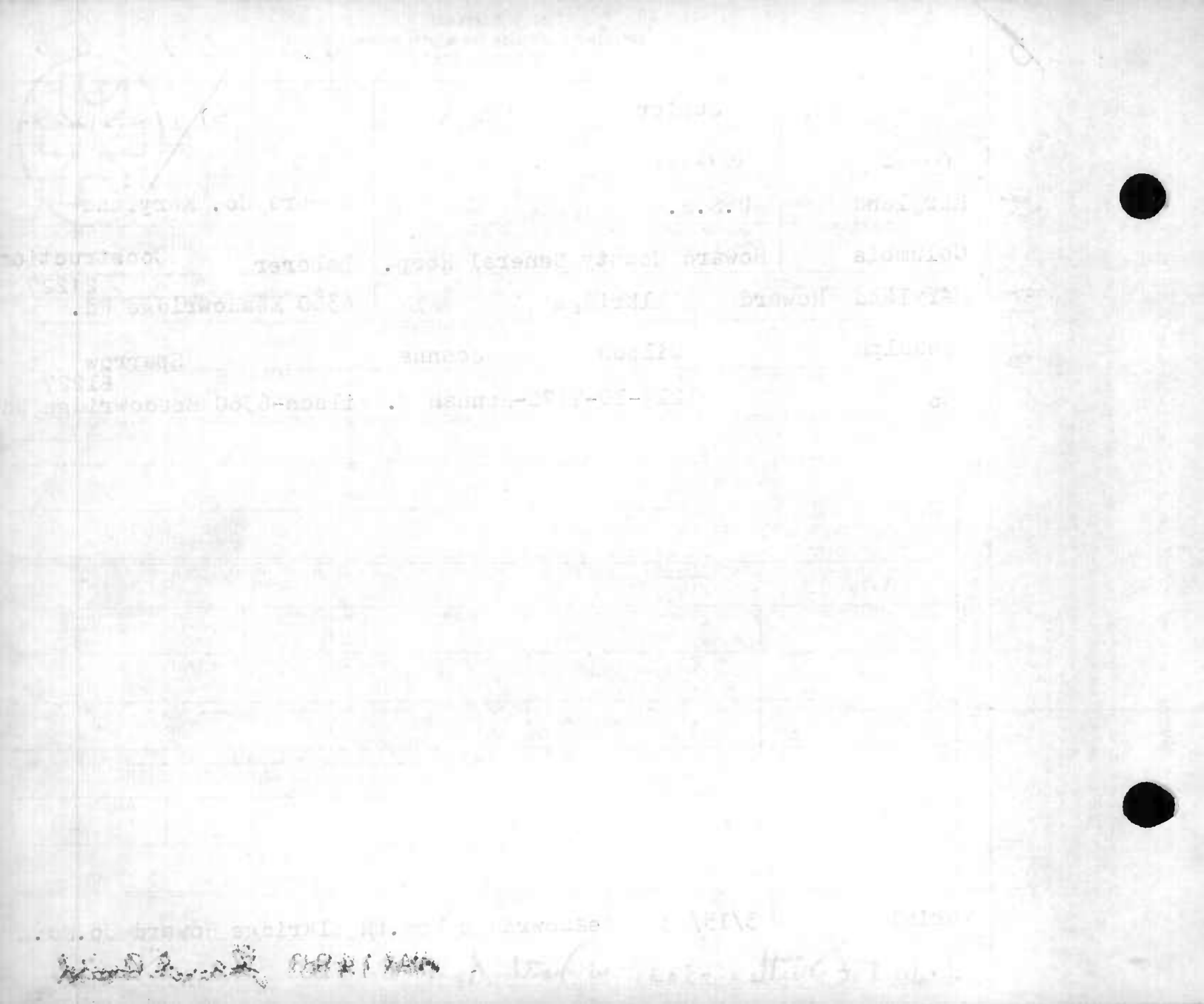
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 7 7 8 8	
1 - FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Elmer Junior Wilson.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>3/11/83</b>		2b. HOUR <b>1225AM</b>			
3 SEX <b>male</b>		4 RACE <b>black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 30 20</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard Co. Maryland</b> MD.					
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
13a. STATE <b>Maryland</b>						13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Elkridge</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Randolph Wilson</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Joanna Sparrow</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-10-7120</b>		17 INFORMANT <b>Hannah E. Wilson</b>		ADDRESS <b>6360 Meadowridge Rd.</b>		21227			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Prostate</b> <b>1850</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pneumonia</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>2/22/83</b> , 19____, to <b>3/11/83</b> , 19____, that (I) (we) lost saw the deceased alive on <b>March 11</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Richard Martin Chasen, M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/11/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD MARTIN CHASEN</b>						22e. ADDRESS <b>1109 Spring Street Silver Spring, Maryland 20910</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>3/15/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Co. Md.</b>					
24 FUNERAL DIRECTOR NAME <b>Hubert E. Rutten</b>						ADDRESS <b>-3835 W. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1983</b>			
						25b. REGISTRAR'S SIGNATURE <b>John A. Carver</b>					

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 07789			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Robert E Woodall</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3-13-83</b>		2b. HOUR MIN <b>0116<sup>A</sup></b>	
3 SEX <b>male</b>		4 RACE <b>Cauc</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>1-30-1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>85</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KANSAS MO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD	
10 CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>md</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Late Robert Woodall</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Ida Cord</b>		13e. STREET ADDRESS <b>7551 Rte 32 21043</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>229-26-6103</b>		17. INFORMANT ADDRESS <b>Hilda Woodall 7551 Rte 32 Columbia MD</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> <b>4349</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pseudotuberculous Polyp</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Cerebrovascular Infarcts</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-8-82</b> , 19 <b>82</b> , to <b>3-12</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>3-12</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sew the body after death.							
22b. SIGNATURE <b>Lawrence Swink</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-14-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAWRENCE SWINK</b>		22e. ADDRESS <b>3459 ST JOHN'S LA.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3-14-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto. MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>	

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1. [illegible]  
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3. [illegible]